HCPCS CODE MODIFICATION PROCESS—MEDICAID

Purpose

The purpose of these instructions is to provide a streamlined process for requesting new codes or changes to existing Healthcare Common Procedure Coding System (HCPCS) codes for services, products, or items, not covered by Medicare, that are needed by state Medicaid programs. These codes are classified as "T" codes for HCPCS purposes. They may or may not be needed by private payers.

General Code Modification Process

The Healthcare Common Procedure Coding System contains alpha-numeric codes used to identify those coding categories not included in the American Medical Association's CPT-4 codes. Under the usual process, a HCPCS National Panel makes decisions pertaining to additions, deletions and changes to the HCPCS. This Panel, which meets three times a year, is comprised of representatives of the Blue Cross/Blue Shield Association, the Health Insurance Association of America and the Centers for Medicare and Medicaid Services. The Centers for Medicare and Medicaid Services (CMS) HCPCS Workgroup, comprised of representatives of the major CMS components, meets approximately once each month to make CMS recommendations to the National Panel pertaining to HCPCS codes. To be considered for inclusion as a permanent code(s) in the annual HCPCS update, the CMS HCPCS Workgroup must receive your completed recommendation packet no later than April 1 of the previous year.

Medicare Code Modification Process

Requests for new codes or changes to existing HCPCS codes for services, products, or items that have implications for Medicare, and requests that relate to durable medical equipment, prosthetics, orthotics and supplies (DMEPOS), or drugs must be submitted by following the procedures outlined at www.cms.hhs.gov/medicare/hcpcs.htm. If you have questions regarding Medicare-related recommendations, you should contact C. Kaye Riley, HCPCS Coordinator, by E-Mail at HCPCS@cms.hhs.gov or by telephone (410) 786-5323. If your recommendation relates to professional services addressed by the American Medical Association's Code of Procedural Terminology code set, you should make your request using the instructions provided on the internet at http://www.ama-assn.org/ama/pub/category/3113.html.

Medicaid Code Modification Process

This process provides an alternative means for state Medicaid agencies to meet their coding needs for services, products, or items which are not represented in the current HCPCS codes and are not covered by Medicare. It is particularly appropriate for states seeking national HCPCS codes to replace local codes that will no longer be recognized in health care transactions as of October 16, 2002 under provisions of the Health Insurance Portability and Accountability Act (HIPAA) of 1996. States should only request national HCPCS codes after first determining that current codes do not identify the service, product, or item in question.

Under this process, the state Medicaid agency (or a group representing state Medicaid agencies) submits its code request directly to CMS's Center for Medicaid and State Operations (CMSO). Medicaid program staff in CMSO initially reviews the request and provides comments to the requester. The requester finalizes the request and returns it (with 35 copies) to CMSO. The formal request is then forwarded by CMSO to CMS HCPCS Workgroup staff. If clarification is needed, the requester will be contacted and provided the opportunity to make changes to its request or additional information.

Workgroup staff distribute your copies of the final submission to the CMS HCPCS Workgroup. Your item and others are placed on an agenda for review against current codes at a regularly scheduled meeting of the Workgroup. Requests for temporary codes that are approved during the regular CMS HCPCS Workgroup meeting are posted on the CMS HCPCS website identified above. In some cases, further information will be requested from the submitter based on Workgroup comments. Code requests that have implications for private payers will be forwarded to private payer representatives on the

National Panel for their review.

Guidelines for Submitting Medicaid Code Requests

When submitting your recommendation, identify one code or a group of similar code requests per submission packet. Do not suggest specific alpha-numeric codes for your individual code requests. The CMS HCPCS Workgroup will assign alpha-numeric codes to those requests it approves.
In addition to providing the information requested below, please include other descriptive material and printed materials which you think would be helpful in furthering the CMS HCPCS Workgroup's understanding of the nature of the service, product, or item and the need for a new code or coding change.

To expedite review, please submit the original request and 35 complete copies of your information packet for distribution to members of the CMS HCPCS Workgroup. We request that these information packets be limited to 40 pages each, and that you **not** submit requests in 3 ring binders. The completed, signed and dated recommendation request and supporting documentation should be bundled securely to ensure that all the submitted information is distributed intact to all reviewers.

Once you decide that a new code or coding change is needed to accommodate a service, product, or item, you may wish to provide us with a draft recommendation for review before submitting a formal request and additional copies. This will enable us to discuss changes that may enhance the likelihood of a favorable decision on your request by the Workgroup.

Healthcare Common Procedure Coding System (HCPCS)
Alpha-Numeric Coding Recommendation Format for the 2003 Update

Instructions:

1. Please **sign and date** each recommendation. Be certain to provide the name, address and telephone number of the person to be contacted regarding this recommendation. **Only state Medicaid agencies or groups representing them can submit code requests under this process.**

2. Please note: **All requested information must be supplied before your recommendation for modifications to the HCPCS coding system can be considered.** The following questions may be transferred to a word processor/computer if additional space is needed to respond. Incomplete submittals will be returned for clarification. **Do not label individual code requests with specific alpha-numeric codes. The CMS HCPCS Workgroup will assign alpha-numeric codes to those requests it approves.**

4. Submit Coding Recommendations to:

   J. David Greenberg
   Centers for Medicare and Medicaid Services
   S2-01-16
   7500 Security Blvd
   Baltimore, Maryland 21244-1850

Alpha-Numeric HCPCS Coding Recommendation Format for 2003 Update

INFORMATION SUPPORTING CODING MODIFICATION RECOMMENDATION

1. Name of service, product, or item:

2. Describe the service, product, or item in general terminology.

3. Define the justification (business need) for this service, product, or item (e.g., change in technology, advance in science).

4. If this service, product, or item is required under Federal/State Law, please provide the "effective date".

5. Why are current codes inadequate to describe the service, product, or item?

6. Provide available information on which other states and payers already cover this service, product, or item, how long they have covered it, how many beneficiaries/patients receive it, how many claims have been paid, and what the total expenditures have been for the service, product, or item?

Recommendation submitted by:

Name:
Name of Organization:
Complete Mailing Address:
Telephone Number:
FAX Number:
E-Mail Address:

_____ _____
Signature Date